APPENDIX 15.4

NEW YORK STATE
FAMILY HEALTH PLUS
MODEL MEMBER HANDBOOK

This handbook will tell you how to use your _____ Plan.

Put this handbook where you can find it when you need it.

HERE'S WHERE TO FIND INFORMATION YOU WANT

WELCOME

PART 1 - FIRST THINGS YOU SHOULD KNOW

PART 2 - YOUR BENEFITS AND PLAN PROCEDURES

WELCOME TO [THE PLAN]'S FAMILY HEALTH PLUS PROGRAM

We are glad that you chose **[THE PLAN]**. We want to be sure you get off to a good start as a new Family Health Plus (FHPlus) member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at **[Member Services #]**.

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

- No doubt you have seen or heard about the changes in health care. Many people now get their health benefits through managed care. Many counties in New York State, including New York City, offer a choice of FHPlus managed care health plans. In some counties, however, there may only be one plan that offers FHPlus. Under FHPlus, people must join a managed care health plan in order to be able to receive health care benefits.

- **[THE PLAN]** has a contract with the State Department of Health to meet the health care needs of people in FHPlus. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our "provider network." You'll find a list in our provider directory. If you don't have a provider directory, call Member Services to get a copy.

- When you join our plan, one of our plan providers takes care of you. Most of the time that person will be your PCP (Primary Care Provider). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you everyday, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can "self-refer" to certain doctors for some services. See page **[___]** for details.

HOW TO USE THIS HANDBOOK

- This handbook will help tell you how your new health care system will work and how you can get the most from **[THE PLAN]**. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.

- The first part of this handbook will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this Handbook or call our Member Services unit. You can also call the managed care staff at your local department of social services. Be sure to tell them you are in the FHPlus Program.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:
Monday through Friday
8:30 AM - 5 PM
Call **[1-800-000-0000]**

If you need help at other times, call us at
[1-800-000-0000]

- You can call to get help **anytime you have a question**. You may want to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report a pregnancy or the birth of a new baby, or **ask about any change that might affect your benefits** (for example, you get a job that offers health care coverage).

- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you.

- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who speaks your language.

- **For people with disabilities**: If you are in a wheelchair, are blind, or have trouble hearing, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with communications devices. Also, we have services like:

    - TTY/TDD machine
    - Information in Large Print
    - Case Management
    - Help in Making or Getting to Appointments
    - Names and Addresses of Providers Who Specialize in Your Disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter. Your Plan ID card should arrive within 14 days after your enrollment date. Your card has your PCP's name and phone number on it. If it's wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. All the benefits that FHPlus covers can be accessed using your plan ID card.

PART I - FIRST THINGS YOU SHOULD KNOW

HOW TO CHOOSE YOUR PCP

- You may have already picked your PCP to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP, you should do so right away**. If you do not choose a doctor within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. You can get help in making a choice from Member Services.

- With this Handbook, you should have a **provider directory**. This is a list of all the doctors, clinics, hospitals, labs, and others who serve the Plan. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You may want to find a doctor:
  - who you have seen
  - who is taking new patients
  - who is on your bus or subway route
  - who understands your health problems
  - who speaks your language

- Women can also choose one of our **OB/GYN** doctors to deal with women's health issues. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine check ups (twice a year), or regular care during pregnancy.

- We also contract with **FQHCs** (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some clients want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose one of our providers, or you can sign up with a primary care physician at one of the FQHCs that we work with, listed below. Just call Member Services for help. **[List available FQHCs here]**

[ALTERNATE LANGUAGE if not contracting with FQHCs]

- Although we do not have a contract with **FQHCs** (Federally Qualified Health Centers), we offer similar services. For example, besides primary and specialty care, these centers have social support services, case management, and classes to help you stop smoking, control diabetes, or lose weight. We have all these services too. For information, call Member Services at **[1-800-000-0000]**.

- In almost all cases, your doctors will be **[The Plan]** providers. There are two instances when you can still **see another doctor that you had before you joined**

[The Plan]. In both cases, however, your doctor must agree to work with **[The Plan]**.

1. You are more than 3 months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery and follow up care.
2. At the time you join, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.

- If you have a long-lasting illness, like HIV/AIDS or other long-term health problems, you may be able to **choose a specialist to act as your PCP.**

[Plans should specify the process]

- If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change once every six months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you.

- If your **provider leaves [The Plan]**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant, or, if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with **[The Plan]** during this time. If any of these conditions apply to you, check with your PCP or call Member Services at **[1-800-000-0000].**

HOW TO GET REGULAR CARE

- "Regular care" means exams, regular check-ups, shots or other treatments to keep you well, advice when you need it, and referral to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works. He or she can help make the system work for you.

- Your care must be **"medically necessary".**

The services you get must be needed:

- to prevent, or diagnose and correct what could cause more suffering, or
- to deal with a danger to your life, or

- to deal with a problem that could cause illness, or
- to deal with something that could limit your normal activities.

- Your PCP will take care of most of your health care needs - but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know. If you can, prepare for your first appointment. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

- If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the "first" appointment.) Use the following list as an appointment guide.

  - adult baseline and routine physicals: within 12 weeks
  - urgent care: within 24 hours
  - non-urgent sick visits: within 3 days
  - routine, preventive care: within 4 weeks
  - first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
  - first family planning visit: within 2 weeks
  - follow-up after a mental health/chemical dependence (including alcohol and/or substance abuse) ER or inpatient visit: 5 days
  - non-urgent mental health or chemical dependence (including alcohol and/or substance abuse) visit: 2 weeks .

HOW TO GET SPECIALTY CARE - REFERRALS

- If you need care that your PCP cannot give, he or she will **refer** you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are plan providers. If we do not have a specialist in our plan who can give you the care you need, we will get you the care you need from a specialist outside our plan. Talk with your PCP to be sure you know how referrals work. If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask our plan to okay before you can get them. Your PCP will be able to tell you what they are.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **"standing referral"**). If you have a standing referral, you will not need a new referral for each time you need care.

- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:

• your specialist to act as your PCP; or
• a referral to a specialty care center that deals with the treatment of your problem.
• hospice services if you are terminally ill

- You can also call Member Services for help in getting access to a specialty care center.

GET THESE SERVICES - *WITHOUT A REFERRAL*

Women's Services:

You do not need a referral from your PCP to see one of our providers IF

you are pregnant, or
you need OB/GYN services, or
you need family planning services, or
you want to see a mid-wife, or
you need to have a breast or pelvic exam.

Family Planning

[Language if covered by the plan]

- You can get the following family planning services: advice for birth control, pregnancy tests, sterilization, or an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.

- You do not need a referral from your PCP to get these services. You can use your Plan ID card to see one of **[The Plan's]** family planning providers. Check **[The Plan's]** Provider Directory or call Member Services for help in finding a provider.

[Alternative language for plans that don't cover these services]

- **[The Plan]** does not provide certain family planning and reproductive health services such as birth control services, sterilization and abortion. You do not need a referral from your PCP to get these services. You can get these services from **[THE DESIGNATED THIRD PARTY PROVIDER].** You may contact your PCP or Member Services for help in getting a list of providers for these family planning services.

HIV Testing and Counseling [when family planning services are covered by the plan)

- You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP. Just make an appointment with one of our family planning providers.

- If you want HIV testing and counseling but not as part of a family planning service, your PCP can arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the NYS HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.

- If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care.

HIV Testing and Counseling [alternate text for plans not covering family planning]

- **[THE PLAN]** does not cover certain family planning and reproductive health services. If you want HIV testing and counseling as part of family planning services, you can get these services from **[THE DESIGNATED THIRD PARTY PROVIDER].** You may contact your PCP or Member Services for help in getting a list of providers for these services.

- You can also get HIV testing and counseling without family planning. You can visit an anonymous testing and counseling site. To get more information about anonymous sites, call the NYS HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS. Or you can ask your PCP to arrange it.

- If you need HIV treatment after the testing and counseling service, your PCP will arrange it.

Eye Care

You do not need a referral from your PCP for an eye exam or to get new glasses or to have your glasses repaired. You just choose one of our participating providers. But remember that you generally are limited to eye exams and new glasses once every two years. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral Health Services

You may go for one (1) mental health and (1) chemical dependence (including alcohol and/or substance abuse) assessment without a referral in any 12-month period. You must use a **[THE PLAN]** provider, but you do not need an OK from your PCP. If you need more visits, your PCP will help you get a referral.

EMERGENCIES

In New York State, an emergency means a medical or behavioral condition:

- that comes on suddenly, and
- has pain or other symptoms.

This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or cause serious disfigurement without care right away. Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing / convulsions / loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting

Examples of **non-emergencies** are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

- **If you believe you have an emergency, here's what to do:**

Call 911 or go to the nearest emergency room, but call your PCP as soon as you can.

- **If you are not sure, call your PCP or [THE PLAN]**.

Tell the person you speak with what is happening. Your PCP or **[THE PLAN]** rep will:

- tell you what to do at home, or
- tell you to come to the PCP's office, or
- tell you to go to the nearest emergency room.

- **If you are out of the area when you have an emergency:**

  - Go to the nearest emergency room.
  - Call **[THE PLAN]** as soon as you can (within 48 hours if you can).

Remember

- **Use the emergency room only if you have a TRUE EMERGENCY**.
- **The Emergency Room should NOT be used for problems like the flu, sore throats, or ear infections.**
- **If you have questions, call your PCP or [THE PLAN] at [1-800-000-0000].**

URGENT CARE

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be an episode of persistent vomiting or diarrhea.
- It could be a sprained ankle, or a bad splinter you can't seem to remove.

You can get an appointment for an urgent care visit for the same or next day. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at **[1-800-000-0000]**. Tell the person who answers what is happening. They will tell you what to do.

WE WANT TO KEEP YOU HEALTHY

Besides the regular check-ups you need, here are some other ways to keep you in good health:

- Health education classes
- Grief / Loss support
- Stress management
- Stop-smoking classes
- Diabetes counseling
- Weight control

Call Member Services to find out more and get a list of upcoming classes.

HANDBOOK – PART 2

YOUR BENEFITS AND PLAN PROCEDURES

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services available under FHPlus. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

FHPlus covers a comprehensive set of health care services or benefits. **[The Plan]** will provide or arrange for all of the covered services. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific "self referral" services, as mentioned above.

SERVICES COVERED BY OUR PLAN

You must get these services from the providers who are in our plan. All services must be medically necessary and provided or referred by your PCP.

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye/hearing exams

Preventive Care

- regular check-ups
- tests and procedures ordered by your PCP or specialist

Maternity Care

Women in FHPlus who become pregnant will qualify for Medicaid because the financial requirements are different and the family size is changed. If you become pregnant while you are enrolled in FHPlus, you have a choice to make. You may want to change coverage from FHPlus to Medicaid. Medicaid covers more services than FHPlus, which you may or may not need, depending on your medical needs. However, you may need to see a different doctor if you change from FHPlus to Medicaid. You should discuss this choice with your doctor and the local department of social services office or HRA so that you can make the decision that best meets your needs.

Your baby will be eligible for Medicaid. Babies can't be covered under FHPlus – it is a program for adults from 19 through 64 years of age. In order to be sure your baby will have access to all the services covered by Medicaid, you need to let your local

department of social services or HRA office know when you are pregnant, and your doctor should notify **[THE PLAN]**. They can get started arranging for coverage for your baby before it is born, regardless of the choice you have made for yourself. You should select your baby's doctor as soon as possible.

If you stay in FHPlus, we will cover:

- pregnancy care
- doctors/midwife and hospital services
- post-partum care

Home Health Care

[THE PLAN] can arrange for some home health care visits, but this is generally only done to avoid your having to stay in a hospital. Your doctor must agree that your medical needs can be met at home with this help. Here are some times when this would be covered:

- if you stay in the hospital less than 48 hours after giving birth
- if you stay in the hospital less than 96 hours after a Cesarean birth
- other visits as needed and ordered by your PCP/specialist

Vision Care

- the services of an ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider.
- eye exams, generally every two years, unless medically needed more often
- glasses (new pair of frames every two years, or more often if medically needed)
- low vision exam and vision aids ordered by your doctor
- specialist referrals for eye diseases or defects

Hospital Care

- inpatient care
- outpatient care
- lab, x-ray, other tests

Emergency Care

An emergency is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent lay person possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result

- in placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in jeopardy; or
- serious impairment to such person's bodily functions; or
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

Behavioral Health Services

[**THE PLAN]** will cover up to 60 outpatient visits or 30 inpatient visits a year for behavioral health services. Behavioral Health Services include Chemical Dependence Services (including alcohol and substance abuse) and Mental Health Treatment Services.

Detoxification Services (Inpatient Detoxification and Inpatient or Outpatient Withdrawal Services) do not count towards the limits mentioned above.

Specialty Care

Includes the services of other practitioners, including

- medical and nursing staff
- occupational, physical and speech therapists needed on a short-term basis
- midwives
- audiologists

Other Covered Services

- Emergency Ambulance
- Durable Medical Equipment (DME)
- Hospice Services
- Hearing Aids/Supplies
- Prosthetics/Orthotics
- Pharmacy (prescription drugs, smoking cessation products, hearing aid products and diabetic supplies from the plan's participating pharmacy)
- Dental **[list only if covered by the plan]**
- Court Ordered services, if covered by the plan.

- TB Diagnosis and Treatment - You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

SERVICES *NOT* COVERED

These services are not available from **[The Plan]**. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Routine foot care (for those 21 years and older)
- Personal and comfort items
- Infertility treatments
- Services of a provider that is not part of **[The Plan]** (unless **[The Plan]** or your PCP sends you to that provider).
- Those services not given an OK in advance by your PCP.
- Personal care services
- Private duty nursing services
- Medical supplies (like bandages), non-prescription drugs (OTCs like aspirin)
- Nursing home stays that are permanent
- Non-emergency transportation (unless you are 19 or 20 and in the C/THP program)
- Dental **[list only if not covered by the plan]**

You may have to pay for any service that your PCP does not ok. This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of the Plan.

If you have any questions, call Member Services at **[1-800-000-0000]**.

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services **[1-800-000-0000]** if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a salary. The number of patients they see does not affect this.

- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many - or even none at all. This is called capitation.

- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an incentive fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by **[THE PLAN]**.

- Providers may also be paid by fee-for-service. This means they get a Plan-agreed-upon fee for each service they provide.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services to find out how you can help.

INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at **[1-800-000-0000]**:

- A list of names, addresses, and titles of The Plan's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the State Insurance Department about consumer complaints about **[THE PLAN]**.
- How we keep your medical records and member information private.
- In writing, we will tell you how our plan checks on the quality of care to our members
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by our plan.
- In writing, we will tell you the qualifications needed and how health care providers can apply to be part of our plan.
- If you ask, we will tell you:
  - whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so,
  - information on the type of incentive arrangements used; and
  - whether stop loss protection is provided for physicians and physicians groups.

KEEP US INFORMED

Call Member Services whenever these **changes happen in your life**:

• you change your name, address or telephone number

• you have a change in circumstances that will affect your eligibility for FHPlus
• you are pregnant
• you give birth
• you become covered under another health insurance

OPTIONS

1. If YOU Want to Leave [The Plan]

You can try us for 90 days. You can ask to leave our plan for any reason at any time during those 90 days, if there is another FHPlus plan available where you live. If you do not leave during the first 90 days of your coverage, you must stay in the plan for nine more months, unless you have a good reason (**"good cause"**). At the end of your first year in our plan you can change to another plan if you want to and there is another FHPlus plan available where you live.

These are examples of **"good cause"**:

• We cannot provide a suitable PCP for you within acceptable travel times (30 minutes or 30 miles from your home, if that's what's usual where you live).

• Our health plan does not meet other State standards and you are disadvantaged because of it.

• You move out of our service area.

• You, the plan, and the LDSS all agree that disenrollment is best for you.

• You are or become ineligible for FHPlus.

[Language for plans in NYC or counties using the enrollment broker:]

Call Medicaid Choice and tell them you want to transfer to another Family Health Plus plan. You will need to get a Transfer Package that will tell you what other plans are available where you live. The transfer package will also have two forms. You will need to fill out the Disenrollment Form. You will also need to choose another health plan. You will need to fill out the Enrollment Form for the new plan. Fill out the forms and mail them to Medicaid Choice. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

[Language for plans in counties without the enrollment broker:]

Just call your local department of social services. Tell them you want to transfer to another Family Health Plus plan, if there is another plan available where you live. You will need to get an Enrollment Package, which will tell you what other plans are available. You will need to fill out a Disenrollment Form. You will also need to choose

another health plan. You will need to fill out an Enrollment Form for the new plan. Fill out the forms and either mail or take them to the local department of social services office. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

2. You Could Become Ineligible for [The Plan]'s FHPlus Program

You may have to leave **[The Plan]** if you:

- move out of the county or service area, or
- have a change in income that makes you ineligible for FHPlus, or
- join an HMO or other insurance plan through work, or
- receive Medicare coverage, or
- join a long-term Home Health Care Program, or
- enter an institution (nursing home, jail, etc.), or
- you turn 65 years of age.

You are **"guaranteed" coverage** by **[The Plan]** during the first six (6) months of your enrollment - even if you are no longer eligible for FHPlus. The reasons for your losing eligibility must not be related to death, moving out of state, or incarceration. During this time you can get the services that our plan covers. Guaranteed coverage does **not** apply if you **choose** to leave **[The Plan]**.

3. We Can Ask You to Leave [The Plan]

You can also lose your membership in **[The Plan]**, if you often:

• refuse to work with your PCP in regard to your care, or
• don't keep appointments, or
• go to the emergency room for non-emergency care, or
• don't follow **[The Plan]** rules, or
• do not fill out forms honestly or do not give true information (fraud), or
• cause abuse or harm to plan members, providers or staff

4. You may want to change from FHPlus to Medicaid with a "spend down"

FHPlus doesn't cover all the services that Medicaid does (like medical supplies), and some services have limits (like physical therapy).

If you have medical needs that could be better met by Medicaid and you qualify, you may be eligible for Medicaid with a "spend down".

If your income is higher than that allowed for Medicaid, but you have medical bills that are greater than the amount your income is over the Medicaid level, those bills could help you qualify for Medicaid. This only applies to people who:

- are under age 21,
- are disabled or blind
- have children under age 21
- are over age 65
- are pregnant (see below also)

You should contact your local department of social services or HRA to see if this is an option for you. If so, they will have you disenroll from **[The Plan]** so that you can receive Medicaid benefits.

5. If you become pregnant while enrolled in Family Health Plus

[Language for FHPlus plans that are also Medicaid managed care plans]

If you become pregnant, you are eligible for Medicaid. You have the choice of staying in FHPlus or changing to Medicaid. You may decide to change to Medicaid because it covers more services. You can stay in **[The Plan]**, but you should ask your doctor if he would continue seeing you as a Medicaid patient, if you change. Your newborn will automatically be eligible for Medicaid and will be enrolled in **[The Plan]**. You should contact **[The Plan]** and your local department of social services office or HRA to discuss these options and your decision.

[Language for FHPlus plans that are not also Medicaid Managed Care Plans]

If you become pregnant, you are eligible for Medicaid. You have the choice of staying in FHPlus or changing to Medicaid. You may decide to change to Medicaid because it covers more services. You should ask your doctor if he would continue seeing you as a Medicaid patient, if you change. If you change to Medicaid you will have to leave **[The Plan]**. You should contact **[The Plan]** and your local department of social services office to discuss these options and your decision.

Your newborn will automatically be eligible for Medicaid. You may need to choose a plan and a doctor for your baby before it is born. You should contact your local department of social services office or HRA to discuss how your baby will get health care services.

CHECKING OUR DECISIONS: UTILIZATION REVIEW

The health plan has a review team to be sure you get the services we cover. Doctors and nurses are on the review board. Their job is to be sure that the treatment given is medically needed and right for the condition at hand. They do this by checking your treatment plan against medically acceptable standards. If you disagree with a treatment plan, our utilization review unit may be able to help. Utilization Review will occur whenever judgments about medical necessity or experimental services are made. You, someone you choose to represent you, or your doctor can make a request to

review our decision about a specific treatment plan. Our failure to make a timely decision has the same effect as a denial. Therefore, if we don't give you a decision in the allowed time, you can ask for an appeal. We will review past care (retrospective review), care that you are seeking (prior approvals or prospective review) and care that you are now getting and want to continue or get more of (concurrent review). Just call Member Services **[1-800-000-0000]** and ask for Utilization Review.

The following treatments or services must be approved before you get them:
• [Note: will vary by plan]

To get approval for these treatments or services you need to:
• [Note will vary by plan]

Three (3) workdays after we get the needed information, we will decide your case. We will let you or your designee and your doctor know by telephone and in writing.

- **If you have been getting care or treatment that should be continued**, or if more services are needed, we will review the request and make our decision within one (1) workday after we get the information we need. We will let you or your designee and your doctor know by telephone and in writing.

- If we are checking on **care that has been given in the past**, we will decide within thirty (30) days.

- If we decide without speaking to your doctor, your doctor may ask to speak to the plan's Medical Director. The Medical Director will talk to your doctor within one (1) workday. If we do not approve your request, we will tell you the reason in writing, and we will tell you or your designee, and your doctor how you can appeal. Your options for asking for an appeal from the State or us will be explained.

UTILIZATION REVIEW APPEALS

You or someone you trust can appeal our utilization review (UR) decision. In the case of past care reviews, your doctor can make the appeal. There are two (2) kinds of health plan UR appeals: fast track and standard.

- Use the **fast track** appeals process when

    - you need an OK to continue current health care, or
    - you need more services added to those you are getting, or
    - your doctor thinks our plan should look at the request again right away.

We will decide on fast track appeals within two (2) workdays after we get the information we need. A medical reviewer will be available to talk with your doctor within one (1) workday after we get notice of the appeal.

- If you, your designee, or your doctor still do not agree with what we decide, you may appeal using the **standard appeals** process.

    - You must file an appeal (by phone or in writing) within forty-five (45) days of getting our decision.
    - Within fifteen (15) days, we will send you a letter to let you know we are working on it.
    - After we get the information we need, we will decide within sixty (60) days. We will tell you or your designee within two workdays of our decision.
    - If we deny your appeal, we will tell you why in writing. We will also tell you how you can make further appeals.
    - If we do not make a decision within the sixty (60) days, we must allow you to get the service you or your doctor asked for.
    - People with qualified clinical training consider your appeal. If you are still not satisfied, we will also tell you the next steps you can take.

EXTERNAL APPEALS

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary, you can ask New York State for an appeal. This is called an "external appeal" because it is decided by reviewers who do not work for **[THE PLAN]** or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

To appeal to the state, you must complete the plan's first level of the utilization review appeal process. You have forty-five (45) days after you receive the plan's final decision from their first level appeal process to ask for an external appeal. If you and the plan agree to skip the plan's appeals process, you must ask for the external appeal within forty-five (45) days.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within forty-five (45) days from the time the plan gives you the notice of final adverse determination from the first level health plan appeal.

You will lose your right to an external appeal if you do not file an application for an external appeal within forty-five (45) days from your receipt of the final adverse determination from the first level internal plan appeal.

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You and your doctors will have to give information about your medical problem. Here are some ways to get an application:

- the NYS Department of Insurance: 1-800-400-8882 or www.ins.state.ny.us

- our member service department at **[1-800-000-0000]**.

Your appeal will be decided in thirty (30) workdays. More time (up to five (5) workdays) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an **"expedited appeal"**. The external appeal reviewer will decide an expedited appeal in three (3) days or less. The reviewer will tell you and **[THE PLAN]** the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

COMPLAINTS AND APPEALS

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below. You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

1. You can file a complaint by phone IF:

- We have denied payment for a referral.
- We have told you a service is not covered.

To file a complaint by phone, call Member Services at **[1-800-000-0000]** Monday - Friday from 8:30 a.m. to 5 p.m. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you. If needed, we will ask you to sign a written statement of your phone complaint. This puts the basic facts of your complaint on record and makes your concerns clear. After your call, we will send you a form that outlines your complaint. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

2. You can file a written complaint for other concerns

- by writing us a letter, or
- by asking us for a complaint form to fill out.
  (To get a complaint form, call us at **[1-800-000-0000]**.
- Mail your complaint (form or letter) to: **[address of Plan's complaint unit]** or FAX the complaint to **[1-800-000-0000]**.
- E-mail your complaint to (plan's e-mail address) (optional)

What Happens Next?

After we get your complaint, we will send you a letter within fifteen (15) working days. We will tell you:

- who is working on your complaint,
- how to contact this person, and
- if we need more information.

After we get all the information we need:

- When a delay would risk your health, we will call you with our decision in forty-eight (48) hours. Then we will send you a letter in three (3) working days.
- If it is about a referral or about benefits, we will tell you our decision in writing in thirty (30) days.
- For all other complaints, we will tell you our decision in writing in forty-five (45) days. When we call or write you about what we decide, we will tell you the reasons. We will also tell you how to appeal our decision and include any forms you need.

You may also file a complaint anytime by calling:

- New York State Department of Health at 1-800-206-8125;
- Your local department of social services;
- or by writing to the NYS Department of Health, Bureau of Certification and Surveillance, Corning Tower, Albany, NY 12237.

Appeals

If you are not satisfied with what we decide, you have sixty (60) business days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. The appeal must be in writing. You can write a letter or use the Plan's complaint form. Call Member Services at **[1-800-000-0000]** for help.

We will send you a letter within fifteen (15) working days. The letter will tell you:

- who is working on your appeal,

- how to contact that person, and
- If we need more information.

Your appeal will be decided these ways:

- Appeals on clinical matters will be decided by qualified health care professionals who did not work on your original complaint.
- All other appeals that are not about clinical matters will be decided by people who work for our plan at a higher level than those who worked on your original complaint.

After we get all the information we need:

- When a delay would risk your health, we will let you know our decision in two (2) working days.
- For all other appeals, we will let your know our decision in thirty (30) days.
- We will give you the reasons for our decision and the medical explanation, if it applies.

If you are still not satisfied, you can file a complaint with:

- New York State Department of Health at 1-800-206-8125;
- Your local department of social services;
- or by writing to the NYS Department of Health, Bureau of Certification and Surveillance, Corning Tower, Albany, NY 12237.

FAIR HEARINGS

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving **[THE PLAN]**.

- You are not happy with a decision that **[THE PLAN]** made about medical care you were getting. You feel the decision limits your FHPlus benefits or that **[THE PLAN]** did not make the decision in a reasonable amount of time.

- You are not happy about a decision **[THE PLAN]** made that denied medical care you wanted. You feel the decision limits your FHPlus benefits.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your FHPlus benefits. You must file a complaint and an appeal with **[THE PLAN]**. If **[THE PLAN]** agrees with your doctor, you may ask for a State fair hearing.

Remember, you can complain anytime to the New York State Department of Health by calling 1-800-206-8125. In some cases, you may be able to keep getting your care the same way while you wait for your Fair Hearing. Call Member Services at **[1-800-000-0000]** if you have questions.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of **[THE PLAN]**, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from **[THE PLAN]**.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or your OK.
- Use **[THE PLAN]** complaint system to settle any complaints, or you can complain to the NY State Department of Health or the local department of social services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.

Your Responsibilities

As a member of **[THE PLAN]**, you agree to:

- Work with your PCP to guard and improve your health.

- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for true emergencies.
- Call your PCP when you need medical care, even if it is after hours.

ADVANCE DIRECTIVES

There may come a time **when you can't decide about your own health care**. By planning in advance, you can arrange now for your wishes to be carried out.

- First, let family, friends and your doctor know what kinds of treatment you do or don't want.
- Second, **you can appoint an adult you trust to make decisions for you.** Be sure to talk with your PCP, your family or others close to you so they will know what you want.
- Third, it is best if you **put your thoughts in writing**. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy - With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR - You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card - This wallet sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

IMPORTANT PHONE NUMBERS

Your PCP:……..……....

[THE PLAN]…….…….……..

Member Services……

Other Units (e.g., Nurse Hotline, UR, etc)……...……

Your nearest Emergency Room…….…...

NYS Health Department (Complaints)…….……1-800-206-8125

Local Department of Social Services……

Local Plan Pharmacy…….....

Other Health Providers…..……